STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155160	A. BUILDING 01 B. WING	02/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEBROOKE REHABILITATION CENTRE & SUITES	990 N 16TH ST NEW CASTLE, IN 47362

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 02/17/12 Facility Number: 000080 Provider Number: 155160 AIM Number: 100289330 Surveyor: Mark Bugni, Life Safety Code Specialist At this Life Safety Code survey, Stonebrooke Rehabilitation Centre & Suites was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This two story facility was determined to be of Type II (111) construction and fully sprinklered excluding the Administration Hall storage room foyer. The facility has a fire alarm system with smoke detection on all levels including the corridors and	K0000	K 000 The creation and submission of this Plan of correction does not constitute an admission by the provider of any conclusion set forth in the statement of deficiencies, or any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	spaces open to the corridors. The facility has a capacity of 152 and had a census of 84 at the time of this visit. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/23/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0017 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 Based on observation and interview, the facility failed to ensure 3 of 14 hazardous areas and 1 of 6 shower rooms were separated from the corridors. This deficient practice affects all 57 residents who reside on the first floor of the facility. Findings include: Based on observations on 02/17/12 during a tour of the first floor from 10:25 a.m. to 12:35 p.m. with the maintenance supervisor and administrator, the following first floor hazardous area rooms and first floor Center Hall shower room were open to the corridor: a. The first floor Administration Hall storage room, which was a hazardous area	K0017	K 0017 - It is the practice of this provider to maintain proper separation from the corridors. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? - To regain the required separation between corridors and use areas all penetrations in the drywall above the drop ceiling assemblies in the areas cited have been patched and appropriately firestopped. Once completed all drop ceiling tiles were reinstalled or replaced as needed. Additionally the Administration hall corridor drop ceiling was reworked so there is no gaps between the grid and ceiling tiles. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective	03/18/2012

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	and measured one hundred twelve square feet with fifteen cardboard boxes of combustible paper and plastic office supplies, had two drop ceiling tiles missing exposing four, three inch to six inch horizontal penetrations in the drywall above the drop ceiling assembly with no fire stopping material around the penetrations between the storage room and the Administration Hall corridor. Furthermore, the Administration Hall corridor drop ceiling assembly had one eighth inch to one half inch gaps where the drop ceiling assembly metal rails were warping and not allowing the drop ceiling tiles to sit flush in the metal rails. b. The first floor Center Hall boiler room hazardous area, which was a fuel fired equipment room, had twelve drop ceiling tiles missing exposing ten, two inch to six inch horizontal penetrations in the drywall above the drop ceiling assembly with no fire stopping material around the penetrations between the storage room and the Center Hall corridor and the nurses' office to the south of the storage room. Furthermore, the Center Hall corridor drop ceiling assembly had one eighth inch to one half inch gaps where the drop ceiling assembly metal rails were warping and not allowing the drop ceiling tiles to sit flush in the metal rails. c. The first floor Center Hall shower room had ten drop ceiling tiles missing		action(s) will be taken? - All residents who reside on the first floor of the facility have the same potential to be affected by the deficient practice. Through facility maintenance inspections if issues such as the above are found they will be repaired. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur? - Through the facility Maintenance Directors building inspections done 5 days per week , if such issues such as the above are found , they will be repaired. How the corrective action(s) will be monitored to ensure the deficient practice will not recur,i.e.,what quality assurance program will be put into place? - Data collected by Maintenance Director through his inspections will be submitted to CQI committee for review and follow up. By what date the systemic changes will be completed? - Compliance date: March 18, 2012	

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	exposing six, two inch to six inch horizontal penetrations in the drywall above the drop ceiling assembly with no fire stopping material around the penetrations between the shower room and the Center Hall nurses' station corridor and the soiled linen room to the east of the shower room. d. The first floor Center Hall boiler room hazardous area, which was a fuel fired equipment room, had twelve drop ceiling tiles missing exposing ten, two inch to six inch horizontal penetrations in the drywall above the drop ceiling assembly with no fire stopping material around the penetrations between the storage room and the Center Hall corridor and the nurses' office to the south of the storage room. Furthermore, the Center Hall corridor drop ceiling assembly had one eighth inch to one half inch gaps where the drop ceiling assembly metal rails were warping and not allowing the drop ceiling tiles to sit flush in the metal rails. The first floor Administration Hall storage room penetrations above the ceiling, the first floor Center Hall boiler room penetrations, and the first floor Center Hall shower room penetrations which were not firestopped and the drop ceiling tile metal rail not allowing the ceiling tiles to sit flush in the metal rails was verified by maintenance supervisor and administrator at the time of observations.			

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	3.1-19(b)			

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K0029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure the corridor door to 3 of 14 hazardous area such as a boiler room were provided with self closing devices which caused the doors to self close and latch into the door frames. This deficient practice could affect any residents who use the first floor main dining room, located across the corridor from the first floor boiler room. Findings include: Based on observation on 02/17/12 during a tour of the facility from 10:25 a.m. to 1:45 p.m. with the maintenance supervisor and administrator, the doors to the first floor boiler room door and the second floor Ashwood Hall supply room which measured two hundred fifty square feet and stored forty nine combustible cardboard boxes of paper, and plastic	K0029	K 0029 It is the practice of this provider to provide doors with self closing devices when applicable. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?- Self closing devices were installed on the first floor boiler room and second floor Ashwood Hall supply room doors. Additionally the soiled laundry room door was reworked and adjusted to close and latch appropriately. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? - All residents of the facility have the same potential to be affected by the deficient practice.Through facility maintenance inspections if issues such as the above are found they will be repaired. What measures will be put into place or what systemic changes will be made to ensure that the deficient	03/18/2012

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	supplies, were not provided with self closing devices. Furthermore, the door to the soiled laundry room which measured two hundred eighty square feet was equipped with a self closing device, but the door failed to close and latch because it was propped open four feet on the concrete floor where the door bottom dragged on the floor. The first floor boiler room door and Ashwood Hall supply room doors lacking self closing devices and the soiled laundry room door not self closing and latching was verified by the maintenance supervisor and administrator at the time of observations. 3.1-19(b)		practice does not recur? - Through the facility's Maintenance Directors building inspections done 5 days per week , if such issues such as the above are found, they will be repaired. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e.,what quality assurance program will be put into place? - Data collected by Maintenance Director through his inspections will be submitted to CQI committee for review and follow up. By what date the systemic changes will be completed? - Compliance date: March 18, 2012.	

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K0038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 1. Based on observation and interview, the facility failed to ensure 2 of 10 exit accesses supplied with delayed egress locks and signs indicating PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS, unlocked when force was applied to the releasing devices. 7.2.1.6.1, requires approved, listed, delayed-egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided the following criteria are met: an irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual	K0038	K 0038 It is the practice of this provider to maintain exit accesses supplied with delayed egress locks are functioning properly. It is the practice of this provider to also ensure sidewalk surfaces on all exit sidewalks are maintained to prevent elevation changes. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? - The delayed egress locks on the Moving Forward Hall and the Administration Hall exit doors were adjusted to ensure proper functioning. To ensure exit sidewalks are maintained to prevent elevation changes a 4x4 section of the cottage sidewalk and a 4x4 section of the kitchen exit sidewalk have been replaced. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? - All residents of the facility have the same potential to be affected by this deficient practice. Through facility maintenance inspections if issues such as the above are found they will be repaired. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?-	03/18/2012

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	means only. Exception: Where approved by the authority having jurisdiction, a delay no exceeding 30 seconds shall be permitted. This deficient practice could affect 26 residents who reside on the Moving Forward Hall. Findings include: Based on observations on 02/17/12 during a tour of the facility with the maintenance supervisor and administrator from 10:25 a.m. to 1:45 p.m., the Moving Forward Hall exit door and the Administration Hall exit door were each equipped with delayed egress locks and signs on each door which read PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS. Both doors failed to unlock the magnetic hold down devices after pressure was applied for thirty seconds to the door latching hardware on three attempts at each exit door. This was verified by the maintenance supervisor and administrator at the time of observations. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure the sidewalk surfaces on 2 of 10 exit sidewalks were		Through the facilty's Maintenance Directors building inspections done 5 days per week , if such issues such as the above are found, they will be repaired. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?- Data collected by Maintenance Director through his inspections will be submitted to CQI committee for review and follow up. By what date the systemic changes will be completed? - Compliance date: March 18, 2012.	

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	maintained to prevent elevation changes. LSC 7.1.6.2 requires abrupt changes in elevation of the walking surface shall not exceed 1/4 inch. Changes in elevation exceeding 1/4 inch, but not exceeding 1/2 inch shall be beveled 1 to 2. Changes in elevation exceeding 1/2 inch shall be considered a change in level and shall be subject to the requirements of 7.1.7. This deficient practice could affect 18 residents who reside on the Cottage Hall. Findings include: Based on observation with the maintenance supervisor and administrator during a tour of the facility on 02/17/12 from 10:45 a.m. to 1:45 p.m., the Cottage exit sidewalk and the kitchen exit sidewalk both discharged from the exit doors onto concrete sidewalks extending forty feet and twenty feet to the parking lot. Both sidewalk surfaces had a four foot by four foot section of broken and heaving concrete with one inch to two inch changes in the sidewalks elevation. This was verified by the			

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	maintenance supervisor and administrator at the time of observations. 3.1-19(b)			

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K0045 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 Based on observation and interview, the facility failed to ensure the lighting in 3 of 10 exit means of egress were arranged so the failure of any single lighting fixture (bulb) would not leave the areas in darkness. LSC Section 7.8.1.4 requires illumination be arranged so the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area. This deficient practice could affect all any resident using the therapy room, and 18 residents who reside on the Cottage Hall including facility staff, and visitors if the facility were required to evacuate in an emergency and any of the single bulb outside light fixtures failed. Findings include: Based on observations on 02/17/12 during a tour of the facility with the maintenance supervisor and administrator from 10:25 a.m. to 1:45 p.m., the therapy room exit, the Cottage Hall exit, and the kitchen exit were each provided with single bulb light fixtures on emergency power leaving	K0045	K 0045 It is the practice of the provider to maintain the proper illumination at exits. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? - To ensure proper lighting in exit means of egress, the single bulb light fixtures at the therapy room exit, the cottage hall exit, and the kitchen exit were replaced with two bulb fixtures. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? - All residents of the facility have the same potential to be affected by this deficient practice. Through facility maintenance inspections if issues such as the above are found they will be repaired. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?- Through the facility's Maintenance Directors building inspections done 5 days per week , if such issues such as the above are found, they will be repaired. How the corrective action(s) will be monitored to	03/18/2012

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	these exit discharges in darkness if the one bulb failed. The emergency generator breaker panels were observed on 02/17/12 at 2:40 p.m. with the maintenance supervisor and administrator and listed outside exit lights on an emergency breaker. The single bulb emergency lighting fixtures were verified by the maintenance supervisor and administrator at the time of observations. 3.1-19(b)		ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? - Data collected by Maintenance Director through his inspections will be submitted to CQI committee for review and follow up. By what date the systemic changes will be complete? - Compliance date: March 18, 2012.	

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K0056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 Based on observation and interview, the facility failed to ensure 1 of 9 corridors were completely sprinklered. This deficient practice could affect any residents who use the Administration Hall. Findings include: Based on observation on 02/17/12 at 10:25 a.m. with the maintenance supervisor and administrator, the Administration Hall corridor outside the storage room had a two foot by two foot area in the corridor with no sprinkler coverage. Furthermore, there was a one foot bulkhead extending from the ceiling which prevented the corridor sprinkler from providing full coverage to the storage room foyer, located in the Administration Hall corridor. This was	K0056	K 0056 It is the practice of this provider to ensure that all corridors are completely sprinkled. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? - To ensure that all areas of the facility are fully sprinkled a sprinklehead was installed in the Administration Hall corridor by PIPE Inc. on March 8,2012. How other residents having the potential to be affected by the same deficient practice will be identified and what correctice action(s) will be taken? - All residents of the facility have the same potential to be affected by this deficient practice. Through facilty maintenance inspections if issues such as the above are found they will be repaired. What measures will be put into place or what systemic changes will be made to ensure that the deficient	03/18/2012

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	155160	A. BUILDING 01 B. WING	02/17/2012

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	verified by the maintenance supervisor and administrator at the time of observation. 3.1-19(b)		practice does not recur?- Through the facility's Maintenance Director's building inspections done 5 days per week , if such issues as the above are found , they will be repaired. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?- Data collected by Maintenance Director through his inspections will be submitted to CQI committee for review and follow up. By what date the systemic changes will be complete? - Compliance date: March 18, 2012.	

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K0144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. 1. Based on record review and interview, the facility failed to ensure the load testing for 2 of the past 12 months was conducted for a minimum of 30 minutes to protect 84 of 84 residents. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised under operating conditions or not less than 30 percent of the EPS nameplate rating at least monthly, for a minimum of 30 minutes. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice affect all residents in the facility. Findings include: Based on a review of the Emergency Generator Monthly Load Test Log Book on 02/17/12 at 9:35 a.m. with the administrator and maintenance	K0144	K 0144 It is the practice of this provider to ensure that generators are inspected weekly and exercised under load for 30 minutes per month.It is the practice of this provider to ensure the off site fuel source is from a reliable source. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?- A letter of reliability with regard to gas service has been obtained from Vectren Energy Delivery. Our current Maintenance Director has been employed since March of 2011 and since that time has maintained inspections of our generator weekly and has exercised under load for 30 minutes per month. Employees responsible for past failed load testings are no longer employed by this facility. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?- All residents of the facility have the same potential to be affected by this deficient practice. Through facility maintenance inspections of maintenance documentation, if such issues as the above are found, they will be	03/18/2012

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	supervisor, the Emergency Generator Monthly Load Test Log Book showed a monthly load test for January and February 2011 for one minute during each monthly load test. Based on an interview with the maintenance supervisor on 02/17/12 at 9:45 a.m., the maintenance supervisor indicated the previous maintenance supervisor started the emergency generator during the January and February 2011 monthly load test for a one minute duration and shut the emergency generator down. This was verified by the administrator at the time of record review and interview. 3.1-19(b) 2. Based on interview and record review, the facility failed to ensure the off site fuel source for 1 of 1 emergency generators was from a reliable source. NFPA 110, 1999 Edition, Standard for Emergency and Standby Power Systems, Chapter 3, Emergency Power Supply (EPS), 3-1.1 Energy Sources states the following energy sources shall be permitted for use for the emergency power supply (EPS): a) Liquid petroleum products at atmospheric pressure b) Liquefied petroleum gas (liquid or vapor withdrawal) c) Natural or synthetic gas Exception: For Level 1 installations in locations where the		corrected. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?- Administrator will review monthly documentation on generator load tests to ensure compliance. How the corrective action(s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurrance program will be put into place?- Data collected by Maintenance Director / Administrator through inspections will be submitted to CQI committee for review and follow up. By what date the systemic changes will be complete? - Compliance date: March 18, 2012.	

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	probability of interruption of off-site fuel supplies is high (e.g., due to earthquake, flood damage or demonstrated utility unreliability), on-site storage of an alternate energy source sufficient to allow full output of the emergency power supply system (EPSS) to be delivered for the class specified shall be required, with the provision for automatic transfer from the primary energy source to the alternate energy source. CMS (Centers for Medicare/Medicaid Services) requires a letter of reliability from the natural gas vendor regarding the fuel supply that must contain the following: 1. A statement of reasonable reliability of the natural gas delivery. 2. A brief description that supports the statement regarding the reliability. 3. A statement that there is a low probability of interruption of the natural gas. 4. A brief description that supports the statement regarding the low probability of interruption, 5. The signature of a technical			

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	person from the natural gas provider. This deficient practice could affect all residents, staff and visitors. Findings include: Based on interview with the maintenance supervisor and administrator on 02/17/12 at 10:15 a.m. during record review, the fuel source for the emergency generator was natural gas. Additionally, based on an interview with the administrator, the facility did not have a letter from their natural gas provider including all the items above required for a letter confirming the reliability of a natural gas fuel source for an emergency generator. The lack of a letter from the natural gas provider was acknowledged by the administrator at the time of interview. 3.1-19(b)			